Mail this form to:
STATE OFFICE OF RISK MANAGEMENT
P. O. Box 13777
Austin, Texas 78711

Please read instruction sheet CAREFULLY, giving special attention to items marked with an asterisk (*).

CLAIM # _____

SORM CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)		2. Sex F ☐ M ☐	15. Date of Injury (m-d-y) - -	16. Time of Injury : am ☐ pm ☐	17. Date Lost Time Began (m-d-y) - -
3. Social Security Number	4. Home Phone ( )	5. Date of Birth (m-d-y) - -	18. Nature of Injury*	19. Part of Body Injured or Exposed*	
6. Does the Employee Speak English? YES ☐ NO ☐ If No, Specify Language			20. How and Why Accident/Injury Occurred*		
7. Employee Telephone #	*8. Block no longer used*		21. Was employee doing his/her regular job? YES ☐ NO ☐	22. Worksite Location of Injury (stairs, dock, etc.)*	
9. Mailing Address Street or P.O. Box			23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site		
City	State	Zip Code County	Street or P.O. Box	County	
10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐			City	State	Zip Code
11. Number of Dependent Children	12. Spouse's Name		24. Cause of Injury (fall, tool, machine, etc.)*		
13. Doctor's Name	Telephone #		25. List Witnesses (Name, Telephone #		
14. Doctor's Mailing Address (Street or P.O.Box)			26. Return to work date (m-d-y)	27. Did employee die? YES ☐ NO ☐	28. Supervisor's Name / 29. Date Reported (m-d-y)
City	State	Zip Code			

30. Date of Hire (m-d-y)	31. Was employee hired or recruited in Texas? YES ☐ NO ☐	32. Length of Service in Current Position Years _____ Months _____	33. Length of Service in Occupation Years _____ Months _____
34. State Payroll Classification Code	35. Occupation of Injured Worker		
36. Rate of Pay at this Job $_____ Hourly $_____Weekly $_____Monthly	37. Full Work Week is: _____ Hours _____ Days	38. Last Paycheck was: $_____	39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☒

40. Name and Title of Person Completing Form Claims Coordinator		41. Name of Agency	
42. Agency Mailing Address and Telephone Number Street or P.O. Box Telephone ( )		43. Agency Location Code _____ _____ _____ / _____ _____ _____ / _____ _____ _____	
City	State Zip Code	Name of Location: _____	
44. Federal Tax Identification Number	45. Primary North American Industrial Classification System Sector Code (NAICS) (2 digits)	46. Specific NAICS Code	47. Comptroller Agency Code
48. Workers' Compensation Insurance Company **State Office of Risk Management**		49. Policy Number **TXSTATEPOL001**	
50. Did you request accident prevention services in past 12 months? YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐		52. Number of Hours of Sick/Annual Leave Credted to Employee or Date of Injury	
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)			

DWC FORM-1S Instructions

PLEASE COMPLETE ALL APPLICABLE FIELDS. Most fields are self-explanatory; however, the following items may require more attention:

Item 4: If no home phone, please give a phone number where the employee can be reached.
Item 7: Employees work phone number.
Item 8: This information is no longer required.
Item 13: This information should include the doctor's telephone number.
Item 15: This should be the actual date of injury, or (for occupational diseases) the date the employee knew or should have known the condition was work-related.
Item 17: This should be the first full day of lost-time from work. (Please note that the date of injury is not considered the first day of lost time.) Mark NLT or N/A if there is no lost time.
Item 18: List the nature of the injury. Examples include: burn, cut, or sprain.
Item 19: List specific body part, which side of body is affected, e.g., chin, **right** leg, **left upper** arm, etc. If more than one body part is affected, list each part.
Item 20: Describe in detail. Use additional sheet of paper if necessary.
Item 24: This should state the specific substance or exposure that directly inflicted the injury such as a tool, chemical (list the name of the chemical), or machine.
Item 26: The date should be entered even if the employee has returned to work even for a portion of the day. If the employee has returned to work making less than his or her pre-injury wage, a DWC FORM-6 must also be submitted.
Item 28: This is the employee's immediate supervisor. Please include a work telephone number.
Item 29: This is the date the employee reported the injury to the employer as work related.
Item 34: This 4-digit code corresponds to the primary occupation in which the employee was engaged at the time of the injury or exposure. This code is from the state payroll classification table and is available from the State Comptroller of Public Accounts.
Item 43: This 9-digit code represents the location of the agency unit that employed the injured worker at the time of their injury or exposure. The first three digits will be 100 for state agencies or 200 for county entities. The second three digits are the agency code. The third three digits are the location code as established by each agency. Contact the SORM's Risk Assessment and Loss Prevention section for information about or changes to your agency location code(s).
Item 44: This 9-digit code is assigned to each agency by the Internal Revenue Service for employment, tax, and reporting purposes.
Item 45: This 2-digit code is assigned to each agency according to its primary business activity. For specific questions regarding your NAICS code, call your local Texas Workforce Commission (TWC).
Item 46: This is a 3- or 4-digit code for the specific subsector of the business activity of the agency.
Item 47: This is the state agency code number assigned by the State Comptroller of Public Accounts.
Item 51: This must be the signature and title of the claims coordinator. If signed by someone other than the claims coordinator, he or she must list his or her title and state that it was signed for the claims coordinator. The date must also be included.
Item 52: Enter the number of sick/annual leave hours credited to the employee as of the date of injury.

Distribution:
Fax a copy **or** mail the original to:
State Office of Risk Management
Mail a copy to the claimant.
Retain a copy for your file.

State Office of Risk Management
P.O. Box 13777
Austin, TX 78711-3777